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TO:	Interested Parties
FROM:	Mollie Baldwin, OES & Jane Connors, Office of MaineCare Services
DATE:	January 13, 2006
SUBJECT:	Section 40, MaineCare Home Health Benefits for Age 21 and older

Section 40 Policy Change Highlights effective January 20, 2006:

Section 40.01: Definitions

New definitions have been added to clarify therapy eligibility criteria changes such as extensive assistance, functionally significant improvement, one person physical assist and rehabilitation potential

Section 40.02-Eligibility for care

- Being determined NF eligible has been eliminated as an eligibility criteria for Section 40 services.
- Section 40.02-E- 13 & 14 Therapies: Visit limits for PT,OT & ST therapy have been eliminated.
- The policy change effective January 20, 2006 includes new requirements when requesting prior authorization for therapies. The admit /start of care form has been revised under the therapy section to accommodate documentation of the items now required by policy. A referral request for therapies must include a copy of physician documentation that the person has rehabilitation potential.
- There are additional criteria (see Section 40.05-C-5a) when a person needs continued physical or occupational therapy. Once the rehabilitation potential has been established by the MD, one of the following criteria must also be met:
    - treatment following an acute hospital stay for a condition affecting range of motion, muscle strength and physical functional abilities.
    - treatment after a surgical procedure performed for the purpose of improving physical function.
    - treatment in those situations in which a physician has documented that the member has, in the preceding thirty (30) days, required extensive assistance (defined in Section 40.01-23) with at least one person physical assist (defined in Section 40.01-24) in the performance of one (1) or more of the following activities of daily living: eating, toileting, locomotion, transfer or bed mobility.
- Every 2 months, the doctor will review the case and decide if the member still qualifies for these services.

How do the therapy requirements change the prior authorization process?

- OES has revised the referral attachment and will require that on referral for PA for therapy that documentation of the rehabilitation potential must be submitted with the referral request in order to be considered complete. For members receiving psychiatric medication services only, who then want to access any therapy, the referral has to include not only the rehabilitation documentation but also documentation related to one of the following criteria:

Required therapy is related to the following circumstances (one of the following must be checked and documentation provided):

- ☐ treatment following an acute hospital stay for a condition affecting range of motion, muscle strength and physical functional abilities.
- ☐ treatment after a surgical procedure performed for the purpose of improving physical function.
- ☐ treatment in those situations in which a physician has documented that the member has, in the preceding thirty (30) days, required extensive assistance (defined in Section 40.01-23) with at least one person physical assist (defined in Section 40.01-24) in the performance of one (1) or more of the following activities of daily living: eating, toileting, locomotion, transfer or bed mobility.

If the referral does not include all the required information on receipt, the referral will be considered incomplete. The official referral date will not be entered and considered for the start of eligibility until all information is received. This type of delay in the date will definitely impact on payment for the provider and may result in non –payment for some services.

Section 40.02-5: The policy now incorporates into it the practice that was implemented **July 1, 2004,** where home health agencies are allowed to serve members meeting the eligibility requirements for Section 40, MaineCare Home Health for up to 120 days before PA is required from GHS.

Current Procedure: If the member requires a 2nd Certification Period, the agency must submit re-certification paperwork (Admit Form, 485 for the 2nd Cert Period and reason out-patient services are contraindicated) to OES within 5 calendar days following the start of the second certification period. Indicate if the paperwork is for the 1st or 2nd Certification Period, by checking the appropriate box on the revised Admit Form. Enter the services that are being delivered as certified by the physician. Enter the start date for each of those services. If disciplines have been added or discontinued between the 1st and the 2nd Cert Period, make the corrections as appropriate, on the Admit Form for the 2nd Cert Period. The member's medical condition must require skilled services on a part-time or intermittent basis, or otherwise no less than twice per month.

- Assessment/Management for a chronic condition is only a covered service for 120 days per admission.
  - If member has had 120 days when PA is requested, assessment management can no longer be authorized for additional certification periods **unless** the member's needs meet the **"Unstable"** definition as defined in Section 40.01-20.

  - Teaching/Training is only a covered service for 120 days per admission. If member has had 120 days of teaching/training do not request PA for this service as the maximum allowed has been accessed **unless** the member's needs meet the **"Unstable"** definition as defined in Section 40.01-20.

MECMS Classification system: With the implementation of the MECMS claims management system a new classification system was implemented. Previously there were 4 classification codes for HH. Now there are 13 classification codes. Each code describes the disciplines allowed under the code and whether or not that code can coexist with other program classification codes. The area most impacted is home health aid services. Many of the LTC policies now clearly define that a member may not receive services viewed as duplicate when paid for under another MaineCare program. For example: If a member is in an Assisted Living facility where personal care is a covered service, policy does not allow for HHA services under Section 40 to be reimbursed. The new classification system is very discrete and has built into the logic the policy parameters.

The classification system feeds MECMS and replaces the classification system in Welfre.

- Claims will kick if a provider bills for a service not allowed under policy while the member receives a similar service from another provider reimbursed by MaineCare.
- If an agency provides a service beyond the end date of the classification, the claim will be rejected.
- If an agency does not submit the admit/start of care forms the claims will be rejected because OES will not have entered any classification into the system. This includes Psychiatric Medication services. Updates to a plan of care where an additional discipline is added must also be received so the appropriate classification code that allows the added discipline will be entered.
- If a member being served by an agency enters a hospital or facility and the agency does not discharge the member the potential for payment problems increases if services are resumed without any notification to OES. Members move from program to program and in and out of facilities to access other benefits. When the program or the benefit involved requires classification codes, these codes are updated as the member accesses different benefits. When Goold assesses a member for LTC and authorizes the benefit we revise the classification system to reflect the change. This may mean a closure of the HH code based on policy and whether or not the new benefit can be provided concurrently with HH.
    - For example: a member may need to access the 30 day Community MaineCare benefit for NF. OES receives from GHS the NF outcome and closes the HH classification and opens the NF classification. If the member returns home within the 30 days and HH resumes services, OES will have shutdown the HH for NF care based on the assessment outcome. If HH agency does not tell us services have been resumed claims submitted will kick due to classification dates.

What has changed?

OES has revised the admit start of care form to include a resumption of services date field. Please begin to submit this form when you have temporarily suspended services to a member under an active certification period due to a hospitalization and a LTC assessment for NF placement or community LTC.

Many times discharge planners make referrals to GHS and a HH agency concurrently. If Goold assesses and offers the waiver, the outcome will reach OES before any HH start of care paperwork has been received. Once a member signs the waiver choice letter at the time of the assessment the waiver classification is entered and HH is not allowed under the EW/ADW benefit. It is allowed under the PDW as long as no personal care provided by a HHA.

Attached are all the revised documents used to communicate with the department as required under section 40.

All documents can be found at: http://www.maine.gov/dhhs/beas/homehealth/homehealth.htm
Copies of the rules are available at : http://www.maine.gov/bms/rules/gen_recently_adopted.shtml

Feel free to call either Lorraine Lachapelle or myself at 287-9200 or 1-800-262-2232.

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